California Department of Education
Fiscal and Administrative Services Division
Form CACFP-F (Rev. 7-2004)

Return to:

California Department of Education
Fiscal and Administrative Services Division
1430 N Street, Suite 2213
Sacramento, CA 95814

Claim for Reimbursement
Child and Adult Care Food Program
Fixed Percentage Claiming Method

Note: Please submit an original and one copy of the claim by the claim submission date of the 10th day of the month following the month claimed. In addition, all claims (original, adjusted, or corrected) must be postmarked by the 20th day of the second month following the month claimed in order to be considered for payment.

All claims must be submitted along with a copy. Retain a copy for the sponsor's files.

1. Affix the mailing label in the space provided below. (If a label is not available, fill in the sponsor's agreement number, name, and address.)

Agreement Number: ☐☐—☐☐☐☐—☐—☐

_____

_____

_____

2. Month covered by this report: Month ____ Year ____

3. ☐ A. This is an original claim.
☐ B. This is an adjusted claim.
☐ C. No reimbursement will be claimed this month.

Items 4 and 5 for State use only.

4. Adjustment Number	5. Reason Code

6. The number of approved sites that operated during this month:…… | |

7. Program Enrollment (See instructions in the administrative manual before completing this item.)	Number of participants eligible for free meals	Number of participants eligible for reducd-price meals	Number of participants eligible for base-rate meals	Total

8. The number of days that program meals were served this month:…… | |

9. Average daily participation (round up the next whole number): …… | |

10. Meals Served	
Breakfast ……	
Lunch……	
Supper ……	
Supplements……	
Total Meals	

I certify that to the best of my knowledge this claim is true and correct in all respects; that records are available to support this claim; that it is in accordance with the terms of existing agreement(s); and that I have not received payment for this claim.

Name of claim preparer (please print):	Telephone number of claim preparer: Extension ( ) ( )	Date:
Signature of authorized official:	Name of authorized official:	Title of authorized official: